LATE-TERM ABORTION: PROTECTING BABIES BORN ALIVE AND CAPABLE OF FEELING PAIN

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TUESDAY, MARCH 15, 2016

United States Senate,

Committee on the Judiciary,

Washington, D.C.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD-226, Dirksen Senate Office Building, Hon. Lindsey Graham, presiding.

Present: Senators Grassley, Hatch, Graham, Lee, Flake, Vitter, Tillis, Feinstein, Durbin, Klobuchar, Franken, and Blumenthal.

Chairman Grassley. A little later on, in just a few minutes, Senator Lindsey Graham is going to take over the Chair, and he is going to give an opening statement, so I will call on Lindsey Graham now and then call on Senator Feinstein.

OPENING STATEMENT OF HON. LINDSEY GRAHAM, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Senator Graham. Well, thank you, Mr. Chairman, and I want to thank all the witnesses for coming, and thank you very much for holding the hearing. This hearing is going to talk about the Pain-Capable Unborn Child Protection Act, S. 1553, which I have introduced with most members of my

conference.

A little bit about this bill. It passed the House 242-184. The Senate failed in vote cloture last year 54-42. To those who may be just watching the hearing for the first time, what we are doing is this bill would prohibit abortion on demand at 20 weeks, the fifth month of pregnancy. We are one of seven countries in the world that allow abortion on demand at that stage in the pregnancy. We are talking about 5 months. But the real novel thing about this bill, it creates a new way to protect the unborn.

Medical science has advanced a lot since 1973, and the standard practice if you operate on a baby in the fifth month of pregnancy at 20 weeks, you provide anesthesia to the unborn child simply because they can feel excruciating pain. I think the medical science is pretty clear on that, that when you try to save the baby's life, you provide anesthesia to the baby so they do not feel the pain required in operating to save their life. The question for the country, really, and the Senate is: Do we want wholesale abortion on demand at that period? If a baby cannot be operated on to save its life without anesthesia, should we allow abortion for any reason at that point in the pregnancy?

Again, we are one of seven countries that allow such procedures, and we are trying to get out of that club, quite

frankly. That is what this whole hearing is about, and on occasion, a baby survives an abortion, and what should we do then? Well, my view is if the baby survives the abortion, is born alive, we should provide every protection in the world to that child that was able to survive an abortion. That is a separate piece of legislation by Senators Sasse and Lankford, but it is included in my bill. We have exceptions for life of the mother and those pregnancies where you have to choose between the baby and the life of the mother. There will be an exception for that. And a pregnancy caused by rape and incest, there is a procedure to deal with that.

But, otherwise, we are trying to advance the cause of protecting the unborn child at the fifth month of pregnancy, 20 weeks. And when you look at medical encyclopedias about what they encourage young parents to do, or parents in general, at that stage in the pregnancy, they are talking about singing to the unborn child because they can recognize your voice, and my view is that if you are supposed to sing to the child because they can recognize your voice, if you provide anesthesia to the child to operate on that child to save their life because they can feel excruciating pain, legislative bodies like the Congress should have the power to protect that unborn child at that stage in the pregnancy.

So that is the purpose of this hearing, and I look

forward to the debate as we move forward. Thank you, Mr. Chairman.

Chairman Grassley. Senator Feinstein.

OPENING STATEMENT OF HON. DIANNE FEINSTEIN, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator Feinstein. Thank you very much, Mr. Chairman. And I am one that is on the other side of this question. I am one that is old enough to know what life was like for young women like many in this room before Roe. I attended Stanford University. I remember young women that were going to end their life because they became pregnant. I remember some passing the plate so that they could go to Tijuana for an abortion.

And then later on, I was appointed by the Governor of the State of California to sit on the Women's Term Setting and Paroling Authority. And we set sentences for women convicted of felonies. At the time abortion was illegal in California. The sentence was 6 months to 10 years. And I remember setting those sentences. I remember giving a woman the maximum sentence because she committed abortions with coat hangers. And I said, "Why do you do this?" And the reason was that she felt sorry for the woman.

So as my life has gone on and I have seen more and more, I have really come to believe that Roe v. Wade is the right thing, that women should be afforded control over

their own reproductive systems. And in the time I have been in the Senate, I have watched the other side of the aisle irrevocably trying to roll Roe back bit by bit, piece by piece.

So where are we today? The 20-week legislation before us has failed already, even in a Senate controlled by Republicans. In September of 2015, the House version of Senator Graham's bill came before the Senate. It was defeated. Cloture was defeated on the floor, even with the support of two Republicans. The vote was 54 yes, 42 no, with 4 absences--Senators Murray, Boxer, Warner, and Murkowski.

I believe it is unconstitutional and explained why on the floor in September. The bill would prohibit abortions pre-viability and does not have an exception to protect a woman's health.

So why are we having this hearing? I view it as a sustained political effort to make it as hard as possible for women to access health care that should be safe and legal.

These papers always stick.

In effect, this effort, if it is successful, will be to drive women underground, away from safe clinics and hospitals, and into areas of serious danger.

An economist and former Google data scientist named

Seth Stephens-Davidowitz just conducted an analysis of the number of Internet searches for self-induced miscarriage. He found that Google searches, and I quote, "show a hidden demand for self-induced abortion that is reminiscent of the era before Roe v. Wade." He wrote, and I quote, "The demand is concentrated in areas where it is most difficult to get an abortion, and it has closely tracked the recent State-level crackdowns on abortion."

In 2015, there were 700,000 searches of this nature, and they included specific searches for where to buy pills on the black market, how to have a coat hanger abortion, how to bleach a woman's uterus, and whether being punched in the stomach causes a miscarriage.

In 2013, Bloomberg News reported on the increasing number of women in Texas buying pills on the black market to induce abortion. One woman interviewed, a mother of four, was on her way to buy these pills at a flea market, and she said, "You would be amazed at how many people, young people, are taking those pills. I probably know 12 to 20 people who have done this. My cousin just went to the flea market a few months ago."

In fact, researchers at the University of Texas have estimated that 100,000 to 240,000 women in the State ages 18 to 49 have tried to self-induce an abortion.

That is to me what it is really like. Should this

procedure be safe or legal? Or should it be driven underground where women will be injured? So that is how it was before a woman's right to make this very personal decision was protected.

Dr. Daniel Mishell recalled how it was in an interview with the Los Angeles Times. At the time he was professor and chairman of the OB/GYN Department at the Keck School of Medicine at the University of Southern California, and here is what he said--I am not going to read the most graphic part of what he said in terms of what happened to many women, but he described botched efforts using coat hangers, bicycle pump nozzles, and chemicals such as drain cleaner. He explained he would see young, otherwise healthy women in their 20s die from the consequences of an infective, non-sterile abortion.

Here is the point: Many of us--and I think it is a majority of the American people--do not want to go back to those days. And the 20-week bill is one step more in that direction, and that is what concerns so many of us.

Women of America I think want the ability to consult with their physicians, to follow their faith, and to make their own reproductive decisions, obviously within the confines of Roe v. Wade and the present viability laws.

So I feel very strongly that this is a mistaken effort, that it will not pass, that it came up in late 2015, and it

did not get cloture. So I am very hopeful that we will not have to go through this a second time.

Thank you very much, Mr. Chairman.

Senator Graham. Yes, ma'am. Thank you, Senator Feinstein. I will introduce the panel, and we will get started here.

Ms. Melissa Ohden--is that right? I got your name right? If I butcher your name, please speak up. She is the founder of the Abortion Survivors Network, Gladstone, Missouri.

Dr. Colleen Malloy, assistant professor, Pediatrics-Neonatology, Northwestern University Feinberg School of Medicine.

Dr. Foster, associate professor, Department of OB/GYN & and Reproductive Sciences, and Director of Research, Advancing New Standards in Reproductive Health, University of California-San Francisco, San Francisco, California.

Ms. Jodi Magee, president and CEO, Physicians for Reproductive Health, Clifton, New Jersey.

Ms. Angelina Nguyen, associate scholar, Charlotte Lozier Institute, Washington, D.C.

Ms. Christy Zink, from Washington, D.C.

And Dr. Kathi Aultman, retired gynecologist, Orange Park, Florida.

So, with that, we will start with Ms. Ohden.

STATEMENT OF MELISSA OHDEN, FOUNDER, THE ABORTION SURVIVORS NETWORK, GLADSTONE, MISSOURI

Ms. Ohden. Thank you so much for your time today, Chairman and Senators. I apologize. I am a little under the weather today, as you can probably hear in my voice, but I am grateful for this opportunity to share some time with you today. I am here--

Senator Graham. You need to--

Ms. Ohden. Oh, gosh. Sorry. Let me start that over.

What I was saying is I am a little bit under the weather today, and now you can tell, but I appreciate your time today, Chairman and Senators.

I am here today to put a face to what late-term abortion looks like and to the importance of infants born alive after abortion being provided timely and appropriate medical care.

In August of 1977, my biological mother, a 19-year-old college student, underwent a saline infusion abortion. In my medical record, you will actually read statements like, "A saline infusion for an abortion was done but was unsuccessful."

A saline infusion abortion involves injecting a toxic salt solution into the amniotic fluid surrounding the preborn child in the womb. The intent of that toxic salt solution is to scald the child to death, from the outside

in.

This type of procedure typically lasted about 3 days. The child soaked in that toxic salt solution until their life was effectively snuffed out by slowly being burned to death, and then premature labor was induced, with the intent of that deceased child being delivered.

I actually did not soak in that toxic salt solution for just 3 days. My medical records indicate that I soaked in it for five. For 5 days, I soaked in that toxic salt solution as multiple rounds of pitocin were given to my biological mother to induce her premature labor with me and ultimately dispel my dead body.

I cannot even begin to imagine the horrible pain and suffering I experienced over those 5 days of the abortion procedure and in the days and weeks that followed thereafter.

On the fifth day of that abortion procedure, I was supposed to be delivered as a successful abortion, a deceased child. But, quite clearly, I was born alive that day. It is by the grace of God alone I am here today to even testify.

I weighed a little less than 3 pounds when I was delivered at St. Luke's Hospital in Sioux City, Iowa, in that final step of the procedure, which indicated to the medical professionals that my birth mother was much further

along in her pregnancy than what she had realized or the abortionist ad recognized or admitted to. They thought that that abortion was being performed at approximately 20 weeks, but my medical records indicate that I looked like I was about 31 weeks gestational age when I was delivered.

Abortion does not spare a child from suffering. It causes suffering. And it did in my case. You would never know by looking at me today, but when I first survived that abortion, the prognosis for my life was actually very poor. I was suffering from severe respiratory and liver problems. I suffered from seizures for an extended period of time. And, sadly, the fight for my life was far from over, of course, when I was delivered in that failed abortion.

In 2013, I learned through contact with my birth mother's family that not only was this abortion forced upon her against her will, but it was my own maternal grandmother, a nurse, who forced that abortion upon her and delivered me in that final step of the abortion procedure.

Unfortunately, I also learned that it was my own grandmother, looking upon my live birth that day at the hospital, who demanded that I be left to die.

I may never know exactly how two nurses who were on staff that day found out about me, but what I do know is that their willingness to fight for medical care to be provided to me ultimately sustained my life, because I know

where children like me were left to die at that hospital: a utility closet. In 2014, I met a nurse who had assisted in a saline infusion abortion there back in 1976, 1 year before I survived. She delivered a little boy, much like me, in the same type abortion procedure. And instead of providing him medical care, she did what her superior ordered her to do, which was to put him in the utility closet in a bucket of formaldehyde where he was left to die alone.

That utility closet and a bucket of formaldehyde was meant to be my fate even after I was not scalded to death in that abortion.

I can only imagine how much would have changed in my world.

I am so thankful that my birth mother's abortion actually took place at a hospital. All that medical care that I so desperately needed and deserved was right there when I needed it. I only doubt, I really do doubt that if that abortion would have happened at an abortion clinic that I would be here today. Those emergency services, the medical care I needed so desperately, would have been much longer coming to me, if it would have been accessed at all. Time is of the essence for children like me.

As a fellow American, as a fellow human being, I deserve the same right to life, the same equal protection under the law, as each and every one of you. Yet we know

that our great Nation falls terribly short when it comes to protecting the most vulnerable of its citizens. We live in a day and time where the science of human development, including fetal pain, the sheer number of survivors like me--I actually know of 207 other survivors much like me through my work with the Abortion Survivors Network, the overwhelming majority of whom are late-term abortion survivors. All of these things clearly show us the truth about life. The truth is clear.

What remains unclear, however, is what you will do in the face of this reality about life. I am here today as one who survived this failed abortion to ask you something that tens of millions of other children cannot because abortion succeeded in ending their life: Will you protect our most vulnerable? Will you assure that children like me are provided proper and timely medical care when we are lucky enough to survive an abortion?

I look forward to seeing how you answer these questions in the days and weeks to come. Thank you.

[The prepared statement of Ms. Ohden follows:]

Senator Graham. Thank you.

Dr. Malloy.

STATEMENT OF COLLEEN A. MALLOY, M.D., ASSOCIATE PROFESSOR, DIVISION OF NEONATOLOGY/DEPARTMENT OF PEDIATRICS, NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE, CHICAGO, ILLINOIS

Dr. Malloy. Hello. I am pleased to have this opportunity to testify on current issues related to your consideration of this legislation.

These bills seek to protect the health and well-being of fetuses and infants beginning at 20 weeks post-conception. This is equivalent to 22 weeks in the dating system used in obstetrics and neonatology, which counts pregnancy by the last menstrual period, the LMP system.

In the LMP system, pregnancy dating starts with the first day of the last menstrual period as day zero. The pain-capable bill is written using post-conceptual age, PCA wording. This is an important point to understand as PCA equals LMP minus 2 weeks. This legislation concerns fetuses and infants beginning at 20 weeks PCA. In neonatologist terms, that equals 22 weeks and beyond by LMP, and this morning I will use LMP dating unless otherwise specified.

With current in utero imaging, blood sampling, and fetal surgery, we have a much clearer view of life in the womb. Our generation is the beneficiary of information that allows us to understand more thoroughly the existence and importance of fetal and neonatal pain. It is standard of

care in my field to recognize, evaluate, and provide treatment as needed for neonatal pain.

With advancements in neonatology and perinatal medicine, we have pushed back the gestational age at which a neonate can be resuscitated and resuscitated successfully. It is easy for us to imagine the lives of infants past 22 weeks as they are moving, reacting, and developing right before our eyes in the Neonatal Intensive Care Unit, the NICU.

Since we resuscitate patients at 22 weeks and beyond, we can witness their ex utero development. In a 2009 series of over 300,000 infants, survival at 22, 23, 24, 25, and 26 weeks LMP was 10 percent, 53 percent, 67 percent, 82 percent, and 85 percent, respectively. In 2015, the New England Journal of Medicine published a series of 5,000 infants in which the survival rate for infants born at 22 weeks who received active treatment in the delivery room was 23 percent. And at 26 weeks, the overall survival rate was 81 percent, where 75.6 percent of survivors had no severe impairment.

Given these survival numbers, the NICU commonly cares for infants born in this gestational age range. We can easily witness their humanity, as well as their experiences with pain. The standard of care for NICUs requires attention to and treatment of neonatal pain. There is no

reason to believe that a born infant would feel pain any differently than that same infant would if he or she were still in utero. The difference between fetal and neonatal pain is simply the locale in which the pain occurs. The receiver's experience of the pain is the same. I could never imagine subjecting my tiny patients to horrific procedures such as those that involve limb detachment or cardiac injection.

Similarly, the location of your birth should not matter, whether it be a hospital, home, ambulance, emergency room, or abortion clinic. An infant born alive via an abortion procedure should be afforded the same protection as an infant born alive in an intended birth. If a medical provider attempts to perform an abortion and the child is born alive, it would make sense that the health care practitioner present would exercise the same care to preserve the child's life and health as would be exercised for a child of the same gestational age in the course of an intended birth. This does not mean that all born infants require full resuscitation; some simply are born too early for full resuscitation with today's technology. However, all born infants deserve medical evaluation and appropriate care in line with neonatal standards.

There is ample evidence--biologic, physiologic, hormonal, and behavioral--for fetal and neonatal pain. Many

authors have substantiated that pain receptors are present and linked by no later than 22 weeks. In fact, by 22 weeks the fetal brain has the full complement of neurons that are present in adulthood. And at 21 weeks electroencephalogram recordings are possible. EEG studies are performed on premature infants. Even when done on extremely premature infants, continuous EEGs show awake and REM sleep states typical of term neonates.

In the NICU, we witness firsthand changes in vital signs associated with pain. When procedures such as IV line placement or chest tube insertion are performed on a neonate at 22 to 26 weeks, the response is similar to that of an older child or infant. With the advent of ultrasound, including real-time ultrasound, we know that even at 8 weeks, the fetus makes movements in response to stimuli. At 22 weeks in utero, a fetus responds to pain, such as with intrahepatic needling, with the same behaviors as older babies. In addition, stress hormones rise substantially with painful blood puncture beginning at 18 weeks gestation. This hormone response is the same one mounted by born infants.

In a 1992 New England Journal of Medicine study, infants undergoing cardiac surgery had large increases in adrenaline, noradrenaline, and cortisol levels. Opioid analgesia--pain medicine--markedly reduced these responses.

Use of analgesia during neonatal surgery is standard of care, and a patient undergoing fetal surgery is expected to receive appropriate pain medication and anesthesia.

In conclusion, I have no doubt that my premature neonatal patients feel and experience pain. Even early on, they demonstrate personalities and interact positively as well as negatively with their environments. With our advanced views into the womb, we can appreciate the active life of the developing fetus as one engaged with the uterine locale. I firmly believe, and the evidence shows, that the fetal pain experience is no less than the neonatal pain experience or even that which you or I would experience from dismemberment or other physical injury.

One of the most basic of Government principles is that the state should protect its members, including all born infants, from harm. In a benevolent society, we must protect the fetus from pain and administer appropriate medical care to all born infants. We should not tolerate the gruesome and painful procedures being performed on the smallest of our Nation. Similarly, we should not offer infant abortion survivors any less medical care than their neonatal peers receive.

[The prepared statement of Dr. Malloy follows:]

Senator Graham. Thank you.

Dr. Foster.

STATEMENT OF DIANA GREENE FOSTER, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF OBSTETRICS, GYNECOLOGY & REPRODUCTIVE SCIENCES, AND DIRECTOR OF RESEARCH, ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, UNIVERSITY OF CALIFORNIA-SAN FRANCISCO, SAN FRANCISCO, CALIFORNIA

Ms. Foster. Good morning. My name is Diana Greene Foster. I am a professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco. I am a research scientist, and I earned my doctorate in demography from Princeton University.

For 20 years, I have done research on the impact of contraception and abortion on women's lives. As part of that work, I lead the Turnaway Study, a longitudinal study of almost 1,000 women who sought abortions from 30 abortion facilities across the country. The Turnaway Study follows women who received an abortion just under the gestational limit of these abortion clinics as well as women denied abortions because their pregnancy was just beyond the gestational limit.

With a team of researchers, I have followed both groups of women, along with women receiving first trimester abortions, through semiannual phone interviews over the past 5 years. It is the largest study of women seeking later abortions and the only one that follows women over time to

ask about their health and well-being.

It is important to understand that nearly one in three American women has an abortion in her lifetime. Later abortions, those at 20 weeks or after, are rare, comprising less than 2 percent of the abortions in the United States. Women are increasingly unable to get the abortions they seek. It is my goal to take a scientific, empirical look at what happens to women who have abortions and what happens when they are denied abortions.

This is what we find. First, women who seek later abortions are very similar to women who have abortions earlier in pregnancy. Some women are delayed because they do not realize they are pregnant--because they have just given birth or because they have never been pregnant before. Once a woman is a few months into pregnancy, the logistical hurdles to getting an abortion, such as finding a clinic and getting there or raising money to pay for the procedure, become much larger. Young women and low-income women often face prohibitive barriers.

We find no significant differences between women seeking later abortions and women seeking earlier abortions in their emotional or psychological responses. Women feel a range of emotional responses to having had an abortion, most commonly relief, followed by in decreasing order sadness, guilt, happiness, and regret. But at every point in the 5

years interviewing these women, we have found that over 95 percent of women report that the abortion was the right decision for them.

In terms of the consequences of denying women wanted abortions, we find that women are thoughtful, even prescient, in the reasons they give for wanting to end an unwanted pregnancy. For example, women most frequently cite financial reasons--that they cannot afford to raise a child or raise another child. And we find that women who must carry unwanted pregnancies to term are more likely to live in poverty 3 years later. They are less likely to have a full-time job and more likely to receive public assistance. They are also less likely to have aspirational plans, like getting a better job or finishing school, and six times less likely than women who receive an abortion to achieve an aspirational plan in the year after being turned away.

Another common reason women in our study cited for wanting to terminate a pregnancy was their concern about being able to care for the children they already have. Our data show there are negative consequences for women's existing children when their mothers are denied the abortions they seek. For these children, we see measurable reductions in achievement of child developmental milestones and an increasing chance of living in poverty. Our research indicates that abortion enables women to take care of the

children they already have and to plan a wanted pregnancy later.

We also find that some women seeking abortion do so out of a concern for their physical safety from an abusive partner. Many women seeking abortion care have poor relationships with the man involved, and one in 20 report physical violence in the 6 months prior to abortion. Women who are able to get their abortions are able to exit abusive relationships. We observe a sharp decrease in violence from the man involved; whereas, women who carry the pregnancy to term experience no such decrease.

One of the likely consequences of a nationwide ban on later abortion is that women will try to end their own pregnancies. As a 21-year-old woman from Texas who was turned away from a clinic told us, "If worse comes to worst, I can go to Mexico and get an abortion or get pills in Mexico. Because everyone knows that is available."

As a researcher, I believe that any law restricting the provision of medical care should take into account the effect on women's health and well-being as determined by sound empirical research, especially laws that restrict a medical procedure that nearly one in three American women experience.

In conclusion, the evidence indicates that a nationwide 20-week ban on abortion will adversely affect the lives of

women and their children across the country.

Thank you.

[The prepared statement of Ms. Foster follows:]

Senator Graham. Thank you.

Ms. Magee.

STATEMENT OF JODI MAGEE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PHYSICIANS FOR REPRODUCTIVE HEALTH, CLIFTON, NEW JERSEY

Ms. Magee. Good morning. My name is Jodi Magee, and I am president and CEO of Physicians for Reproductive Health. Physicians for Reproductive Health is a national doctor-led organization that uses evidence-based medicine to promote sound reproductive health policies. Our founder, Dr. Seymour Romney, believed that doctors have a public health responsibility to speak out in support of access to abortion and contraception.

Recently, States have imposed hundreds of restrictions on abortion, some under the guise of protecting women but all designed to limit women's access to safe and legal services. These laws try to shame, pressure, and punish a woman who has decided to have an abortion.

All patients deserve dignified, compassionate, and appropriate medical care. Every woman faces her own unique circumstances, challenges, and potential complications. She must be able to make medical decisions based on her doctor's advice and what is right for herself and her family--without interference from politicians.

Make no mistake: The legislation we are discussing today represents another attempt to make it impossible for women to access abortion. Because politicians know that the

public and major medical groups do not support this position, they are disingenuously presenting these restrictions as only applying to very limited circumstances. But let us be clear: This is part of a concerted effort to intrude on the personal health decisions of women.

Our physicians are profoundly committed to women's well-being and have a long track record of delivering safe, legal care. That is why we are extremely concerned about these continuing legislative attacks.

In the past 4 years alone, State legislatures across the country have passed more than 230 bills to limit access to reproductive health care. The result has been that abortion has quickly become out of reach for countless women.

The recent assaults on abortion care are reminiscent of the time before Roe v. Wade when abortion access depended on a woman's socioeconomic status, where she lived, and her ability to travel. A woman's right to a safe and legal abortion should not depend on her zip code.

Despite a lack of evidence of wrongdoing, heavily edited and discredited videos claiming to "uncover" illegal activity at Planned Parenthood clinics have been used by lawmakers as a reason to increase restrictions on women's access to abortion. A result of these kinds of false claims has been an increase in threats and violence directed at

abortion providers.

Last fall, a gunman entered a Planned Parenthood in Colorado and killed three people. This was the most recent attack in a long line of murders, arsons, and other incidents of violence directed at those who provide abortion service--and the women they serve.

Physicians for Reproductive Health deplores the incendiary rhetoric that dehumanizes the courageous doctors who are literally putting their lives on the line to provide safe and legal abortion care.

The legislation under discussion today is nothing more than the latest effort to ban abortion. While the vast majority of abortions take place well before 20 weeks, doctors and their patients may determine that abortion care after 20 weeks is necessary for a variety of reasons. These bills deny women that option, even in complicated health circumstances.

The legislation also threatens physicians with criminal penalties in an attempt to deter doctors from providing abortions. But this has dire consequences for women. When doctors are facing complex, urgent medical situations, they need to be able to focus on providing the best treatment for their patients and not delay as they consider whether their professional judgment will land them in prison. In no other area of medicine is this kind of political intrusion into

medical care tolerated.

Since Roe, the United States has a long history of legal, safe abortion care. Today, abortion has an enviable record in medicine, with a 99 percent safety rate and a less than 1 percent complication rate. We should not be singling out such essential care for medically unjustified regulations. That is why organizations like the American Congress of Obstetricians and Gynecologists oppose these deceptive bills.

Physicians that provide abortion place the highest priority on their patients' safety and well-being. I ask that this Committee trust women, trust their doctors, and work to protect access to safe, legal abortion. A patient's unique circumstances and her physician's medical advice, not a politician's opinion, should determine the care she receives.

Thank you.

[The prepared statement of Ms. Magee follows:]

Senator Graham. Thank you.

Ms. Nguyen.

STATEMENT OF ANGELINA BAGLINI NGUYEN, ASSOCIATE SCHOLAR, CHARLOTTE LOZIER INSTITUTE, WASHINGTON, D.C.

Ms. Nguyen. Good morning, Mr. Chairman, honored members of this Committee. Thank you for the opportunity to testify today in support of the pain-capable bill and the abortion survivors bill.

I am an attorney and legal researcher, working for the Charlotte Lozier Institute in Washington, D.C., as an associate scholar. I have published extensive research on comparative international law and U.S. public policy. Previously I served as a Fellow for another policy think tank in Phoenix, Arizona, where I compiled and analyzed statutory and case law from all 50 States. I teach undergraduate philosophy, where a major component of the class is to analyze political society and the rule of law.

The United States is one of only seven countries in the world that permit elective abortion past 20 weeks. Upholding laws that restrict abortion past 20 weeks would situate the United States closer to the international mainstream, instead of leaving it as an outlying country with ultrapermissive abortion policies.

In comparing international law, we compiled a sample group of 198 countries, independent states, and semiautonomous regions with populations exceeding 1 million.

Of these 198 independent states and regions, 59 allow abortion without restriction as to reason, otherwise known as "elective abortion" or "abortion on demand." The remaining 139 countries require some baseline reason to obtain an abortion ranging from most restrictive--to save the life of the mother or completely prohibited--down to least restrictive--for socioeconomic grounds--with various reasons in between--the physical health or the mental health of the mother.

Currently, the United States permits abortion on demand through viability, and the state's interest can come in only post-viability, usually marked around 24 weeks.

Of the 59 countries permitting elective abortion, nine countries limit elective abortion before the 12th week; 36 countries limit elective abortion at 12 weeks; six countries limit elective abortion somewhere between 12 and 20 weeks; and only seven countries permit elective abortion past 20 weeks or have no gestational limit.

More than 75 percent of the countries permitting abortion without restriction as to reason do not permit elective abortions past 12 weeks gestation. That is commonly known as the first trimester. Only 12 percent--7 of the 59 countries--allow elective abortion past 20 weeks.

The U.S. is among these seven countries. This is true whether 20 weeks is measured from the last menstrual period-

-otherwise known as gestational age--from conception, or from implantation. No matter how duration of pregnancy is measured, all of the countries in this category pass the 20-week threshold. The countries are: Canada, China, the Netherlands, North Korea, Singapore, the United States, and Vietnam.

The United States is within the top 4 percent of most permissive abortion policies in the world--7 out of 198 countries--when looking at abortion restrictions based on duration of pregnancy.

Permitting abortion on demand past 20 weeks places the U.S. among the most permissive countries in the world. And if more States were to adopt policies like the pain-capable bill, we would align ourselves closer with the international norm which limits elective abortion at 12 weeks. Policies imposing gestational limits on elective abortion have been overwhelmingly adopted by countries that uphold elective abortion policies, and they encourage women's safety in limiting abortion to early pregnancy and policies that protect unborn children from pain and prolonged exposure to the risk of abortion.

Twenty-week abortion laws are neither extreme nor unreasonable. Rather, they move the U.S. closer to international norms of legislating what is safe and healthy for the mother and grants unborn children more protection in

the womb.

Thank you.

[The prepared statement of Ms. Nguyen follows:]

Senator Graham. Thank you.

Ms. Zink.

STATEMENT OF CHRISTY ZINK, WASHINGTON, D.C.

Ms. Zink. Good morning, members of the Committee. My name is Christy Zink. Thank you for allowing me to share my story here today.

The preschool classroom is bright and welcoming. Paintings on the wall delight the eye with their big, blue splotches. Legos, toy trains, puppets all wait on tables for those little hands to play.

This morning, like many, I have seen my daughter off to her third-grade class down the hall, and I am taking a few extra minutes in the pre-K room before I rush off to work, to read a book to my son and his friends, and to take in their energy and wonder at the world. They have even written their own book together with their teacher's help: "A Day in the Life of the Kindness Snails."

That is them, this class, The Kindness Snails, their own invented name, and it is strangely perfect. Amidst the rambunctiousness of being 4 and 5 years old, there is also a definite through-line of respect. The class rules, which they have agreed upon through a class vote, read this way: "Use Kind Words. Gentle and Safe Bodies. Listen. Take Care of Each Other."

These lessons together echo in my head as I speak to you today. Such basic tenets feel especially important, because I relearn them alongside my 4-year-old son. He is

my rainbow baby. He is here today, thriving, and I am here today to mother him, because I had access to safe, legal abortion when I most needed it, after 20 weeks of pregnancy. Listen, please.

I was pregnant in 2009. I took extra special care of myself, receiving excellent prenatal attention. I breathed a sigh of relief when the pregnancy advanced past the first trimester. I grew more excited with each test that showed a baby growing on target.

But you can enter into an exam room with all good hopes for the anatomy scan more than halfway through pregnancy and leave with the first in a series of terrible but undeniable facts. I could not have imagined the heartbreaking news my husband and I would learn at that late stage of pregnancy.

When I was 21 weeks pregnant, an MRI revealed that our baby was missing the central connecting structure of the two parts of his brain. A specialist diagnosed the baby with agenesis of the corpus callosum. What allows the brain to function as a whole was simply absent. But that was not all. Part of the baby's brain had failed to develop. Where the typical human brain presents a lovely, rounded symmetry, our baby had small, globular splotches. In effect, our baby was missing one side of his brain.

Living in Washington, D.C., we had access to some of the best specialists in the world. We asked every question

we could. The answers were far from easy to hear, but they were clear. No one could look at those MRI images and not know, instantly, that something was terribly wrong. While they could not give us hope, leading medical professionals offered us their support, expertise, and the gift of the truth. Amidst the worst of news, kind words.

This condition could not have been detected earlier in my pregnancy. The prognosis was unbearable.

If a 20-week ban had been in place then, I would have had to carry to term and give birth to a baby whom the doctors concurred had no chance of a life and who would have experienced near constant pain if he survived. His condition would require surgeries to remove more of what little brain matter he had, to diminish what would have otherwise been a state of near constant seizures. Wires, tubes, machines, scalpels, surgery, pain, and more pain. My daughter's life, too, would have been irrevocably hurt by an almost always absent parent.

Safe bodies. The decision I made to have an abortion at almost 22 weeks was made out of love and to spare my son's pain and suffering. At no point would the sort of political interference under consideration have helped me or my family. It would not have added safety. It would, in fact, have heaped unnecessary struggle in a time of grief. Instead, the abortion care I received was safe, expert,

gentle, and compassionate.

This proposed legislation does not represent the best interests of anyone, not the medical professionals who humanely and objectively explained to us the prognosis and our options, not the doctor who helped us terminate the pregnancy, and certainly not families like mine. What happened to me during pregnancy can happen to any woman.

Take care of each other. It is in honor of my son that I am here today, speaking on his behalf. I am also fighting for all women to have the same right to access safe, legal, high-quality abortion care when we need to beyond 20 weeks--even for those women who could never imagine they would have to make this choice.

Women need abortion care for a variety of reasons at various stages of pregnancy. That a woman like me can receive devastating news about the state of her pregnancy only after 20 weeks is only one example of why we cannot--and should not--legislate against the multitude of reasons women choose to end pregnancies.

Let us work at truly taking care of each other. This proposed legislation creates dangerous situations for women and families. It interferes with the exchange of medical information between women and their doctors. It takes away essential choices that women need to consider with their partners, their medical teams, and the people they trust

most. If we are to take care of, to treat each other as equals, then it begins by recognizing that abortion is a private decision, made not under threat of unfair law, but within the context of our own real and complex lives.

Thank you.

[The prepared statement of Ms. Zink follows:]

Senator Graham. Thank you.

Dr. Aultman.

STATEMENT OF KATHI A. AULTMAN, M.D., RETIRED GYNECOLOGIST, ORANGE PARK, FLORIDA

Dr. Aultman. Chairmen Grassley and Graham and Committee members, thank you for inviting me to participate today.

I have spent my entire career as an advocate for women and women's health. I have done first- and second-trimester abortions and have treated women with the medical and psychological complications of abortion. I have taken care of women who decided to keep their unplanned pregnancies and those who aborted them. I have given birth vaginal vaginally twice, and I have had an abortion. My cousin survived an abortion.

When I entered medical school, I believed that the availability of abortion on demand was solely an issue of women's rights. During my residency I was trained in first-trimester abortions using D&C with suction, and I sought and received special training in second-trimester D&E during which the fetus is crushed and removed in pieces.

As I examined the tissue after each procedure, I was fascinated by the tiny but perfectly formed organs. However, because of my training and conditioning, the human fetus seemed no different to me than the chicken embryos I dissected in college.

I was not heartless. If a patient came to me after the

loss of a baby she had wanted, I was distraught with her and felt her pain. What made the difference for me was whether or not the baby was wanted.

In my second year of residency, I got a job moonlighting at a women's clinic in Gainesville doing abortions. I felt I was doing something for the good of women, and I could make more money doing than working in an emergency room. The only time I had any qualms about doing second-trimester abortions was during my neonatal care rotation when I was trying to save babies who were about the same age as some of the babies I had aborted.

When I became pregnant, I continued to do abortions without any reservations, but when I returned to the clinic after my delivery I was confronted with three situations that changed my mind about doing them.

I discovered that I had personally done three abortions on a girl scheduled that morning. When I protested, the clinic staff said that it was her right to choose to use abortion as her birth control method and insisted that I had no right to pass judgment on her nor to refuse to do the procedure. I told them that it was easy for them to say. I was the one who had to do the killing. She got her abortion and admitted that she still was not going to use birth control.

The second case involved a woman who, when asked by her

friend if she wanted to see the tissue, replied, "No. I just want to kill it!" I felt like saying, "What did that baby ever do to you?"

The third patient was a mother of four who did not feel she and her husband could afford another child. She cried throughout her time at the clinic. I finally made the connection between fetus and baby. I realized that what struck me was the apathy of the first patient and the hostility of the second towards the fetus, contrasted with the sorrow and misery of the woman who knew what it was to have a child.

I realized that the baby was the innocent victim in all of this, and the fact that it was unwanted was no longer enough justification for me to kill it. I could no longer do abortions.

My views also changed in private practice as I saw young women in my practice who did amazingly well after deciding to keep their unplanned pregnancies, in contrast to those who were struggling with the emotional aftermath of abortion. That was not what I was expecting. I assumed that those who kept their babies would be the ones whose lives would be ruined.

I will never forget one woman who saw me for bleeding problems after a late-term abortion in Orlando. She had not recovered from the horror of delivering her 20-plus week

baby boy into the toilet. Her baby brother had died by drowning.

Another woman told me that she was seeing a psychiatrist because although she strongly believed in a women's right to choose abortion, she could not cope with the realization that she had killed her child.

In fact, it was not until after I had my first child that I regretted my earlier decision and mourned the loss of the child I had aborted.

Few doctors are able to continue to do abortions for very long. Physicians are taught to heal and do no harm. They see the broken bodies, and eventually the truth sinks in.

We have sanitized our language to make abortion more palatable. We do not speak about the "baby." We talk about the "fetus." The abortionist "terminates the pregnancy" rather than "kills the baby." We have moved further away from the idea that life is precious and closer to the utilitarian attitudes that destroyed so many lives during the last century.

We have taught our young women that an unwanted pregnancy is the worst thing that can happen to her and that abortion is the only logical solution. Should a baby who can live outside the womb be given no consideration, no protection, and no rights just because she is unwanted? Can

we not at the very least have compassion on babies at 20 weeks gestation--22 weeks from last menstrual period, which is what most women and their OB doctors label it--when their nervous systems are developed enough for them to experience pain? Can we at least ensure that babies who survive abortion are not deprived of the same care we would give any other baby at the same gestation just because someone did not want them?

The joy of meeting young adults who I helped bring safely into the world is clouded now by the knowledge of all those that I will never meet because I aborted them.

I want to thank you for your vital efforts to protect those who cannot protect themselves and thank you for your consideration of these views.

[The prepared statement of Dr. Aultman follows:]

Senator Graham. Thank you all.

Senator Grassley, would you like to go first?

Chairman Grassley. Thank you all for your testimony.

Dr. Malloy, you have testify that unborn children after 20 weeks of the post-fertilization mark are capable of experiencing pain. You also have suggested that unborn babies may possibly perceive pain with even greater intensity than full-term.

How can it be medically acceptable for doctors to routinely use anesthesia for life-saving procedures on infants in utero and yet these doctors do not use anesthesia for infants in the same gestational age who are being subjected to late-term abortions?

Dr. Malloy. Yes, it does seem to be a great disconnect between the experience that we have in neonatal and fetal medicine, and fetal surgery has come a long way, and the operations that they are doing to perform to save babies in utero and then the pregnancy even continues is--those babies all receive anesthesia for those procedures.

If I could, I would like to show a picture of what a 25-week baby looks like. I think sometimes it helps. It helps me, actually. If you could just see what one of my patients looks like, it is hard to say that that baby would not feel pain. When these babies are circumcised, they get anesthesia for that. So we have a picture that I wanted to

show you. This is a 25-week baby by LMP right when they are born, which is 23 weeks post-conceptional age. This baby, everything from smiling, positive reactions, to negative ones, if it is being stuck for blood, it winces, it cries, it moves away from the needle. I mean, they react just as you or I really would just on a smaller level. And I think this is a great picture because you can see that little boy, and they are so--neonates, and especially, I think, premature neonates are so fantastic just to observe. And even a small child would--if you asked, "What is that right there?" That is a baby. And there is no reason to think that that baby would not feel pain just because they were born early.

Chairman Grassley. The next question to Dr. Malloy and Dr. Aultman. As Ms. Ohden testified, her testimony illustrates not all abortions succeed. In a case where an unborn child defies the odds and survives the infusion of lethal chemicals or the use of instruments and is born alive, it would seem that the infant would need immediate care in a facility with the ability to tend to it.

What do you think should happen if an infant survives an abortion and is born alive? Am I correct that all infants who survive an abortion should be required to be transferred to a hospital as soon as possible?

Dr. Malloy. Yes, I do think that that baby should be

transferred to a hospital as soon as possible because the neonatologist and people that could assess the gestational age, assess the infant, and treat that baby with the same care that any baby born in the hospital would receive. Some babies are simply born too early for resuscitation, but it really has to be left to a neonatologist or a pediatrician to determine that.

Chairman Grassley. Dr. Aultman?

Dr. Aultman. Yes, I completely agree with that.

Chairman Grassley. Okay. I have a question for Ms. Ohden. You testified that you know 207 other survivors of failed abortion. In your view, what experiences are common to all abortion survivors? And what lessons, if any, should Congress draw from your experience and the experience of others who are in the Abortion Survivors Network?

Ms. Ohden. Thank you, Chairman. Of the 207 other survivors that I know of, I can only think of less than 5 who were unsuccessfully terminated in a first trimester. As I said, the overwhelming majority are late-term survivors like me. If you passed most of us on the street, you would actually never guess in a million years that we survived the type of procedures that we did. But I also know of many survivors who are missing limbs, who have had major organ issues, you know, folks who have stayed in the hospital almost their entire lives, because of the complications that

they have suffered after an abortion. And I think there are so many lessons to learn from lives like mine.

First of all, you know, this is the truth about abortion. You know, we have lost 58 million children in our country, and this is what they would have looked like in some way, shape, or form if only they had been allowed to live.

I think there are great lessons to be learned not only about the truth of life, but also in perseverance. You know, so many people like me, even if we have no physical issues, the emotional, the mental, the spiritual battles that we face living in the kind of culture that we do are many. So I know that I am speaking not only for children who never have the chance to speak because of abortion, but I have the great opportunity to be a voice for so many of those survivors who would never have the opportunity to share their story with you.

Chairman Grassley. Thank you.

Senator Graham?

Senator Graham. Senator Blumenthal I believe, is that correct? He is not here?

Senator Franken. Well, I think we are going to go to Senator Durbin.

Senator Graham. Okay.

Senator Durbin. Thank you very much, Mr. Chairman.

The feelings on this issue are intense and personal. I know it from a lifetime in politics. We are not likely to change one another's basic views on the underlying issue.

There are a couple things that I would like to ask about. One is, it is my belief--and I believe experience suggests it is valid--that the incidence of unplanned and unintended pregnancies has a direct relationship with the number of abortions; and that if a woman is given access to family planning to make decisions about her family, it is less likely she will have an unintended, unplanned pregnancy. That to me is as clear as human experience.

We have these hearings about abortion, which are very emotional and people feel very strongly about it. But we are not including in this hearing another important set of facts. We are continuing to restrict access to family planning in America. And as we restrict access to family planning, there are more unintended, unplanned pregnancies which lead to more abortions.

If we are serious about reducing the number of abortions, we need to start with access to family planning. Instead, what we are seeing is a steady drumbeat from the other side of the aisle about reducing, if not eliminating, the Title X Family Planning Program.

And that is not all. When we talked under the Affordable Care Act of extending the coverage of health

insurance to include contraception, we ended up in a battle royal over religious belief. States, many States, have turned down access to Medicaid to poor women, which is their avenue, their opportunity to have family planning. We cannot adopt policies on family planning in Washington that restrict access to birth control and then sit here and decry the obvious result of more abortions. That to me is as clear as night following day. And yet that is where we are at this moment.

I could go through the list of efforts to stop family planning funding beyond Planned Parenthood. I will not. But it is a matter of record. For the last 4 or 5 years, the House, which is under control of the majority party, has consistently voted to defund family planning programs while decrying the number of abortions in this country. That makes no sense to me whatsoever.

I would like to say to Ms. Zink thank you for your testimony. It is clear that you are a loving mother who faced an impossible moral choice. And you made that choice, and you came today to tell us that you had to make it, and you felt you had no choice.

I have met mothers like you in Illinois, mothers who have been told, "If you continue this pregnancy, you will endanger your own health, let alone this baby that you are carrying that will never survive." And the ones who have

come to talk to me had children afterwards. This is not some callous, heartless decision on the part of women. And when we set up these barriers, 20 weeks, 22 weeks, whatever the number may be, we ignore the obvious exceptions to the rule where most reasonable people would say, "Wait a minute. That is a different set of circumstances." When we try to make these hard and fast rules and say we are going to stick with these hell or high water, we ignore the moral dilemmas that many families, loving families, face when they are in this circumstance. And I thank you for your testimony here.

Mr. Chairman, I do not have any questions. I just wanted to say those things for the record. Thank you.

Senator Graham. Thanks, Senator Durbin.

Dr. Malloy, is it generally accepted medical practice that if you are operating on a baby at 20 weeks or 22 weeks, whatever term you want to use here, that you provide anesthesia?

Dr. Malloy. So definitely, if you are performing neonatal surgery, they would receive anesthesia. And even in fetal surgery, which is a fascinating, expanding field, they would receive anesthesia either through the placenta or given directly to the baby.

Senator Graham. Because they can feel pain.

Dr. Malloy. Because they can feel pain, and also the surgeons--because they feel pain, you would not want a baby

wincing and moving around. A surgeon has to be able to operate on that child, so because they feel pain, they do not want that pain reaction of kicking and wincing and moving away. In addition, the outcomes are worse if you do not use anesthesia. A long time ago, people did not treat neonates truly as patients that need anesthesia, and their outcomes were very poor because the cortisol levels were sky high, the adrenaline levels sky high. You know, the biological response to instrumentation is not conducive to a successful surgery.

Senator Graham. That is the best way to achieve a successful outcome, is to provide anesthesia.

Dr. Malloy. Yes.

Senator Graham. Dr. Foster, apparently only seven countries in the world allow--does anybody disagree with what Ms. Nguyen said in terms of legal analysis?

Ms. Foster. I have studied what happens in countries that are in the other club, the ones with lower gestations than we have, and banning abortion does not make it go away. It makes it much more likely that women have an illegal abortion. So what happens in these other countries that are not on that list of seven is that, for example, a woman in South Africa, when denied a legal abortion, went and tried to find another clinic, and they told her it was as clinic, and, no, when she got there, it was a trailer behind a cell

phone shop where some man was going to put pills in her lady parts. So being part of this club where women can safely, legally access abortion might be the right club.

Senator Graham. Well, that is a matter of opinion, but the point I am making is that you have studied the effect that abortion has on women.

Ms. Foster. Yes.

Senator Graham. Have you seen in these other countries women who have abortion at 20 weeks and beyond? What are your results there? How does it affect--we have got most of the world to look at here, and so are we seeing in these other countries that ban abortion at 20 weeks--

Ms. Foster. What happens when abortion is banned is that you get much higher maternal mortality from unsafe abortion. It is the second leading--

Senator Graham. That is not my--

Ms. Foster. --cause of death.

Senator Graham. That is not my question. My question is you talk about the psychological impact of a woman having an abortion, and I appreciate your testimony. It seems that most countries ban elective abortions after 20 weeks. Is there a body of evidence to show that people in those countries, the women in those countries experience what you are talking about?

Ms. Foster. There is no evidence internationally or

domestically that women have psychological problems after abortion. Is that your question?

Senator Graham. Well, your testimony was that women are adversely affected.

Ms. Foster. By carrying unwanted pregnancies to term.

Senator Graham. Right. But my point is that--well, I think you have answered the question. There is no evidence to suggest that women in these other countries are experiencing what you are talking about.

Ms. Foster. There is evidence that women who are denied abortions because their country's gestational limit is lower than ours go on to seek illegal abortion. So I told you about the woman in South Africa--

Senator Graham. I got you.

Ms. Foster. --but I could tell you women in Colombia, Bangladesh, Tunisia, South Africa--okay, I told you South Africa. Anyway, five countries that I have studied where, after being denied an abortion, what happens is that women consider illegal abortion.

Senator Graham. Yes, ma'am. Okay.

Dr. Magee, do you believe that there should be any restrictions on abortion at any time?

Ms. Magee. Senator, just for the record, I am not a doctor, so I just want--

Senator Graham. Sorry.

Ms. Magee. That is all right. Could you repeat the question? I am sorry.

Senator Graham. Do you believe there should be any restrictions on abortion at any time?

Ms. Magee. Physicians for Reproductive Health believes that the safety and health of women is paramount, so if there are going to be restrictions on abortion, they should serve the needs of women.

Senator Graham. Okay. Ms. Ohden, did you ever reconcile with your grandmother?

Ms. Ohden. Unfortunately, my grandmother is deceased, but I have been very blessed in my life to have contact with both my biological mother's family and my birth father's family. My birth mother and I have not met yet, but I am grateful to have her be a part of my life. And I know that what happened to me seems incredibly dramatic to many people. The fact that it was forced upon her is an incredibly tragedy. But there was also an additional tragedy in her life. The secret that I survived was actually hidden from her for over 30 years. I am an adoptee. And I am not sure if we had a picture prepared for today. I apologize. Is it? I want to show you all a picture of me. I did not have the opportunity to share it either, but it is a picture of me at actually 25 days old. I was transferred to the University of Iowa hospitals, and

in this picture I weigh 2 pounds 10 ounces. I had fought back after I was fighting for my life. That is little old me at 25 days old, 31 weeks gestation.

Senator Graham. Thank you.

Ms. Ohden. I am grateful for the opportunity to share that with you all today.

Senator Graham. Senator Franken.

Senator Franken. Thank you, Mr. Chairman.

Ms. Zink, thank you for your courage to come here today and for your story. Let me ask you this: If Senator Graham's bill were to become law, you would have been prohibited from getting the abortion that you needed on the child that was not going to be able to survive, right?

Ms. Zink. Correct.

Senator Franken. Okay. And what would that have meant to you and your ability to have the child that you talk about in your testimony that was born after that child, that incident, that baby?

Ms. Zink. I think that there is a sense that abortion and motherhood are separate, but it is not. Right? And the doctors were very kind to us and gave us really the most expert opinions at the top of their field to talk to us not just about the medical realities but to talk to us with what they had seen at Children's Hospital with seeing babies in this sort of situation.

One of the situations was that the baby would never leave the hospital, and one of the things that they asked us to think about was: What would it mean to only have one parent for your current child? I think the fact that my son is here and that he is healthy and that we are a family is absolutely due to the good expert medical care that we received.

Senator Franken. And, Ms. Magee, would this law take into account the health of the mom?

Ms. Magee. It does not, Senator.

Senator Franken. So, in other words, if the decision to go ahead--you could have the situation where you have a fetus that is not viable, and that it could--by going to term, you would make it so that the mother could not have babies again, it would affect her reproductive system, that if this law became--if this bill became law, that mother would have to sacrifice not being able to have babies again?

Ms. Magee. Yes. One of the things that is a problem with this law is that it limits women's choices and forces them into situations that they find untenable. And it seems to me to be punishing women at the same time. These kinds of restrictions, which we are seeing all over the country, do nothing for the health and safety of women seeking abortion services. Most women seeking abortion services are already mothers, and it seems to me that they know best what

they need to parent, and that these kinds of restrictions take that kind of control of their lives out of their hands. And in this particular case, it also forces doctors to be worried about being put in prison.

Senator Franken. Dr. Foster, as a researcher, you have examined the consequences of reduced access to abortion. In your testimony, you state that "women are increasingly unable to get the abortions they seek." Drawing on the data that you have collected for the Turnaway Study, is it fair to say that restrictions that put safe abortion services out of reach have led some women to take matters into their own hands?

Ms. Foster. It is very difficult to study women seeking illegal abortion in the United States. In my study, that did not happen. But it is true that the consequences of denying women abortions are extremely serious, and in my Turnaway Study--

Senator Franken. Tell me about those consequences.

Ms. Foster. In my Turnaway Study, one woman denied an abortion in a Midatlantic State, a 24-year-old, died after giving birth, within 10 days of giving birth. If she had received an abortion, the complications associated with abortion are much lower than the complications associated with carrying a pregnancy all the way to term and having a birth. So, yeah, 20-week restrictions pose serious threats

to women's health.

Senator Franken. Thank you.

Thank you, Mr. Chairman.

Senator Graham. Senator Vitter.

Senator Vitter. Thank you, Mr. Chairman. Thank you all for being here.

Do any of you, including the minority witnesses, disagree that any child born alive, whether after a failed abortion or not, should get all available medical care for survival? Does anyone disagree with that?

Ms. Magee. Senator, please repeat that, and I would be happy to answer.

Senator Vitter. Sure. Do any of you, I said specifically including the minority witnesses, disagree that a child born alive, whether it is after a failed abortion or not, should get all available medical care for survival?

Ms. Magee. I do not disagree with that. I think that the doctors who care for women who are receiving abortion services have the health and well-being of their patients utmost in their minds. And they are looking for the best possible health outcomes. And we should leave it to doctors to make those decisions, and we should be leaving it to women to make the choices about their own pregnancies.

Senator Vitter. So just to be clear, nobody disagrees that a child born alive should get all available medical

care for survival? Dr. Foster?

Ms. Foster. I think that the problem with this bill is that it treats all pregnancies the same, and there are pregnancies--

Senator Vitter. I did not ask about the bill. I just asked--

Ms. Foster. --where the--I do disagree that--I can imagine situations where the doctors and nurses have decided that there is not a point in medical intervention, and by whisking the baby away, you have taken away a woman's chance to hold her child and say good-bye.

Senator Vitter. Okay. So if there is care available toward survival, you think that in some cases that care should be denied?

Ms. Foster. I think that the law says that the child has to be taken away and receive medical care if there are signs of life, which does not allow for the physician or nurse or, more importantly, the wishes of the family to say that they do not think that care is going to help in this case, and that they want to be able to hold their child.

Senator Vitter. And if the care could lead to survival, do you think that that should be able to be denied?

Ms. Foster. I think that doctors and nurses and women themselves know best whether care would lead to survival.

This bill does not allow that judgment to be made.

Senator Vitter. Okay. Other witnesses?

Dr. Aultman. I disagree with what you are saying. The worst complication for an abortionist is to have the baby born alive, and I do not feel that the abortionist has the best interests of that child at stake. And the mother may not either. The bill is not saying that you must give that baby extraordinary care. They are just saying you have to give them the same care you would give any other baby at that gestation. And at that gestational age, they do need to be where they can get the best help, and the mother can go with them.

Senator Vitter. Any other witnesses? Yes.

Ms. Zink. I first want to say that I am not a legal expert, and I do not know exactly what the law says. But I do think this question of survival is more complicated. And I just want to clarify that with our situation, it is the complexity. Right? So there is a possibility--let me back up.

There is a possibility that this situation in itself that his diagnosis was not lethal. But if he had been born, he would have been born into a life of seizure, of pain, of suffering, and that to me is--this question of survival gets very complicated. And I think that those were conversations that I needed to have with my doctor, that I needed to have

with medical experts, that we needed to have with people who were very well versed in what does it mean to be a neonatal, what does it mean to be born into this state.

Senator Vitter. Okay. Dr. Malloy?

Dr. Malloy. I would just like to add that sometimes in neonatology you do not have all the information until the infant is born, and there are plenty of children who have seizure disorders who do not live a life of pain and suffering. And the medical providers performing the abortions are not the right ones to assess the outcome and quality of that child that is then born alive. So that baby definitely should be taken to a medical facility where pediatric and neonatologists can look at the child and take things from there.

Senator Vitter. I am sorry. My time is running out. Let me just get one more question in. Again, for all of the witnesses, does anyone disagree that a child, a fetus at 22 weeks is capable of feeling pain? Is there any disagreement about that?

Ms. Magee. I disagree.

Senator Vitter. You disagree?

Ms. Magee. There is no medical evidence that shows that fetuses feel pain until the third trimester.

Senator Vitter. And why is it normal medical practice to give a child at that age anesthesia?

Ms. Magee. Senator, I am not a doctor, so I cannot speak clinically. But I know of the medical evidence that is in the literature today, and there is no evidence that suggests that fetal pain exists until the third trimester.

Senator Vitter. And you have no opinion about why in that case such a child is given anesthesia?

Ms. Magee. I cannot speak to the clinical question. I am sorry.

Senator Vitter. Okay.

Ms. Nguyen. If I may just--and I think my medical colleagues I think can speak to this more clearly, the majority of scientific evidence that is out there, and reports, shows that children by at least 20 weeks do respond to pain and have pain stimuli in place. There is one report of the many hundreds of reports on fetal pain and fetal science, the JAMA report, which maybe the minority witnesses are referring to, that says, you know, one developmental stage that has not been in place for a child in the third trimester is what is required for pain. But the majority of scientific evidence is heavily favored in the direction that a child by at least 20 weeks, and usually before 20 weeks, is able to perceive and feel pain.

Dr. Malloy. I would definitely agree with that, and that is why anesthesiologists and surgeons and neonatologists use pain medication, because it is supported

by the literature completely.

Senator Graham. Mr. Blumenthal.

Senator Blumenthal. Thanks, Mr. Chairman.

I have long believed that decisions by women about their reproductive rights ought to be made by them in consultation with their family, their clergy, and, most important, with their doctors. None of us on this panel is a doctor, and none of us in the United States Senate or in Congress or anywhere in Government ought to be interfering with women's rights based on scientific decisions where we are completely unqualified to make judgments, and these decisions really ought to be made without legislative interference, in my view. That is what Roe v. Wade essentially said. It is the right of privacy. It is a constitutional right.

We do have some physicians and doctors and scientists with us today, and I would like to ask you, Dr. Greene Foster, because you have looked at restrictions on the doctor-patient relationship on a national scale, about some of the impacts that you have seen as a result of both State and Federal restrictions on these rights.

Ms. Foster. The most relevant to this conversation is the 20-week ban, and in 2013, before several States had implemented their own State-level 20-week ban, we estimated that over 4,000 women were already being denied wanted

abortions because they showed up too late for an abortion, for the last abortion in the--first of all, later abortions are very difficult to get in the United States already, and most providers have lower gestational limits, and it takes a lot of money and resources if you need a later abortion to get one. And we found that if you go to these last-resort clinics, these places that go the latest, they were turning about 4,000 women away a year.

So I think the ban that has the biggest effect in directly preventing abortion is a gestational limit ban. You know, we have investigated ultrasound viewing and found that it makes no difference in--you know, it seems like it might be--it does not seem to make any difference in women's decisionmaking. I am trying--there are so many restrictions. It is hard to--waiting periods, my colleague Sarah Roberts has shown that a 24- or 48-hour waiting period actually delays abortions by over a week because of scheduling and--help me on restrictions. Sorry.

Senator Blumenthal. That is a very good answer, and you can supplement it for the record.

Ms. Foster. They have unintended consequences and usually not to make abortion unavailable except for the 20-week bans.

Senator Blumenthal. Thank you.

Ms. Magee, your organization was founded by doctors who

believe that patients deserve dignified, compassionate, and appropriate health care. Can you tell us what you hear from those physicians and others about your concerns for their patients when abortion is banned or otherwise made inaccessible, what they hear from their patients, what you hear from them? And do such restrictions place patients at greater risk of injury, infertility, or even death?

Ms. Magee. Yes, they do, Senator. So let me answer the last part of your question, and then I will come back. I think it was Senator Feinstein who said earlier, talked about the increase in the problems associated when you restrict abortion services. So this particular ban would not allow women with fetal anomalies or women who have pregnancies that are compromised later in the pregnancy. So, for instance, if it is a healthy pregnancy but then the woman is diagnosed with a form of cancer that competes with--the medication for the treatment for the cancer competes with a healthy pregnancy or being pregnant, those are part of the reasons why we need access later because we cannot determine in any particular case what is going to happen, and we need doctors to be able to make the best medical decisions for women and the best medical decisions for women in consultation with them for their best health outcomes. So restricting abortion, this particular ban does not allow that for physicians or for the women they care for.

If I might also add, our organization was founded by doctors in the early 1990s, and most of those doctors had seen incidences of illegal abortion and the results for women, and that is part of the reason for the founding of the organization, is that they saw women coming in after illegal abortion attempts and felt that it was in conflict with the role of doctors to care for the best interests of women. So our founder, Seymour Romney, had--he remembered vividly 40 years later a 16-year-old who had tried to self-abort by putting darning needles in her uterus, and he was faced with trying to both save her life and--the pregnancy and save her life. And the only way they were able to do that was to provide her with a hysterectomy. So this young woman at that point lost all ability to have future pregnancies or to raise her own biological family, and it was that kind of experience prior to Roe that inspired the doctors who founded our organization to speak out on these issues.

I hope I have answered your question.

Senator Blumenthal. Yes. Thank you very much.

Mr. Chairman, my time has expired, but I would like to submit for the record a letter from Jodi Abbott, Aviva Lee Paretz, and Glen Markinson, all of them medical doctors, and a separate letter from the vice president for public policy at the Guttmacher Institute, Susan A, Cohen.

Senator Graham. Without objection.

[The letters follow:]

/ COMMITTEE INSERT

Senator Graham. Senator Hatch.

Senator Hatch. Well, it seems to me that the medical doctors on the panel disagree on fetal pain with sociologist doctors on the panel. I am just saying it seems to me that the medical doctors on the panel disagree with the sociology doctors on the panel who are social scientists with regard to fetal pain, which I think clouds the issue quite a bit.

Dr. Aultman, a study published by the Guttmacher Institute found that most women seeking late abortions are "not doing so for reasons of fetal anomaly or life endangerment." Now, is that consistent with your experience as a practicing gynecologist for more than 30 years?

Dr. Aultman. Actually, yes, and when some of the late-term abortionists, some of the infamous ones, were actually questioned, they admitted that most of these were not done for maternal or fetal indications. And I think that is where Government does come into play, that we do have an obligation to protect those that cannot protect themselves. And I had the opposite experience of Senator Feinstein. What I saw was that throughout my career abortion was expanded and expanded and expanded, and even when I was pro-abortion and was doing D&E's, I was appalled at the D&X procedure, and I could not figure out why they were not arrested for doing that.

And then to hear that--to learn that there were babies

that were being killed or put in a closet after they had survived an abortion was unconscionable to me. And the fact that we do these kind of things tells me that, yes, there do need to be some laws in place to protect. And I think it is a wonderful thing now that we have things like perinatal hospice which can support families that have babies with fetal anomalies.

Senator Hatch. Thank you. I appreciate your testimony.

Dr. Malloy, in Roe v. Wade the Supreme Court said that a legislature may reasonably choose a point in pregnancy when the interest and the life of the unborn child becomes significant. Now, the Court drew the line at what is called "viability," defined as when a preborn child is "potentially able to live outside the mother's womb, albeit it with artificial aid."

This legislation draws the line at 20 weeks when the preborn child can feel pain. Now, I am a lawyer, not a doctor, but I used to be a medical liability defense lawyer. But the lines of viability seem to me subjective, changing and dependent on external circumstances, such as artificial aid. The line of fetal pain seems to me objective, stable, and derived from physical characteristics of the child.

Now, I would invite your comments on this based on your knowledge and perspective as a neonatologist.

Dr. Malloy. Viability has definitely shifted to a lower gestational age. Even in my training, when I started 10 years ago, it is even in the lay press that babies are surviving at 22 weeks by LMP, and the things that we can do in the NICU are amazing and watching the babies grow. And a lot of, I think, the discussion here today, I think we have to remember that we are really focusing on 22 weeks and beyond here. A lot of kind of general statements have been made about abortion in general, and you saw the picture of the baby that I put up. I mean, it--my 10-year-old daughter even said to me, "It is hard to believe we are even having a discussion about things like a baby born alive and then what?"

So we really--we are obligated to protect the undefensible, and the babies are viable and surviving, and patients like Melissa, a 31-week baby alive and kicking, her life should not be dependent on one nurse that kept her from the utility closet.

Senator Hatch. On that point, to follow up, the Supreme Court said in Roe v. Wade that it drew the line of viability "in the light of present medical knowledge." Now, is this legislation drawing the line of fetal pain "in the light of present medical knowledge"?

Dr. Malloy. I think I am best probably sticking to my milieu of the NICU and what my neonatal patients and fetal

patients are like. I really probably should not expand on broader policies, to be honest, but I will just tell you, if you just saw what we are seeing in the neonatal ICU, you saw 22-, 23-, 24-week babies, you would be pleasantly surprised at how active and involved and--even I agree with what the doctor said about perinatal hospice. Even for babies with difficult fetal diagnoses, the literature definitely supports that mothers who carry those babies to deliver them and even if they do not survive more than a couple days or a week, the family is able to hold the baby, feel closure, feel that they have, you know, seen what that baby is like after they are born and kind of had--what has been happening for centuries is that people have difficult fetal and neonatal diagnoses, it just happens since the dawn of time, and so to carry that baby to deliver and care for that baby in that time afterward is a very humane and supportive, compassionate way to--and that is where perinatal hospice comes into view as well, to support those families who have babies with difficult diagnoses.

Senator Hatch. Thank you, Mr. Chairman. My time is up.

Senator Graham. Senator Tillis.

Senator Tillis. Thank you, Mr. Chair. Thank you all for being here. Ms. Zink, I particularly appreciate you being here, and, Ms. Ohden, you as well.

Dr. Foster, I want to make sure I have got the numbers right, and I have a question for Dr. Aultman. You said in your opening testimony some 2 percent of the total number of abortions were late-term abortions. Is that correct?

Ms. Foster. Later abortions, meaning after 20 weeks.

Senator Tillis. Okay, after 20 weeks. So that would be--

Ms. Foster. And I think it is closer to 1 percent, but I did not want to seem to be pushing it.

Senator Tillis. Okay. So that would be somewhere on the order of, since Roe v. Wade, around a million, 750,000 to a million in the later term, or I think in 2011, if you apply the statistics, somewhere around 22,000 later-term abortions, to use your words, that were committed. So although it is a percentage, it is a significant number, in the thousands of tens of thousands every year.

Ms. Aultman, in your time when you completed abortions, was there ever any incidents where you would have noted some reaction to pain in connection with those procedures?

Dr. Aultman. No, not really because I could not se--I could not see what was happening.

Senator Tillis. Okay. One thing I did want to mention, and Senator Durbin's comments about family planning, I think we can all agree that we should provide options earlier. I think the debate around family planning,

at least speaking for myself, is not about not wanting to have an expectant woman absolutely informed on the options. Let us just make sure that they are all the options and the potential tradeoffs over the course of the term of their pregnancy. I think if we did that, then we could virtually eliminate all but serious medical conditions for late term.

Actually, I had a question for Ms. Nguyen. Ms. Nguyen, there are some people who are against the bills--and I want to thank the Chair for his leadership on this--who will point to it maybe not being constitutional and that there will be all kinds of challenges. Given that argument, why wouldn't we see more challenges to the State bills that have been passed on this subject? Why would that be? Why would they not be challenged?

Ms. Nguyen. You know, this piece of legislation is, as we said, extremely well liked in polling. It is very reasonable, with regard to our standing, you know, in the international norm. Sixteen States have passed a pain-capable version of the bill. Only three have been enjoined--Georgia on the State level, Idaho and Arizona in the Ninth Circuit. As we have seen, the Ninth Circuit has not exactly, you know, set the stage for national abortion--national policy. But we see in these other States where the 20-weeks laws, notably in Texas, that has not been challenged is that this 20-week policy can stand under and

alongside the viability rules in place with Roe. This is a new state interest, one of first impression that the Court would see. It has never examined fetal pain as being a new protected state interest. That may have a different durational limit of 20 weeks as opposed to what Roe determine viability was for the purely moral grounding of when life begins. Viability on a moral ground begins at viability, but for an unborn child that can feel pain, that duration may very well be 20 weeks. The Court could find that there is a different durational limit. It did not--the Court in Roe did not directly address any kind of durational limits, and so it can stand alongside it.

Also, as Dr. Malloy mentioned and Senator Hatch mentioned, the viability rule as a standard is becoming more and more nebulous as the science develops and we see an increase in, you know, our medical capabilities, that once at 28 weeks in 1973 as fetal viability has dropped down to 24 weeks, and we see, you know, the New England Journal of Medicine recently published that at 22 weeks a child can survive and is considered viable if they have the right hospital care and standard of care doctors.

So I do not think we should be looking to set, you know, legal standards that are dependent upon what hospital access that you have or what kind of medical care you may receive, but at 20 weeks we are creating a bright-line rule

that says that all children, no matter where they are or what access to care that they have, are going to be protected from pain at 20 weeks, you know, especially this state interest. Our country has gone to a lot of lengths to protect pain for both persons and non-persons. We see, you know, going to great lengths for death row inmates for them to avoid a painful dying process. We also see animal cruelty cases being prosecuted very strongly to avoid pain in non-persons.

So pain is a specific and important new state interest that I think the Court could uphold either alongside the viability rule or without it.

Senator Tillis. Mr. Chair, I made--that was a very good answer, but I made the mistake of asking the attorney the question too early into the cycle so it bled over into my time. May I ask just two very brief questions?

Senator Graham. Absolutely.

Senator Tillis. Thank you very much for the question. I am new here.

Dr. Aultman and Dr. Malloy, if you two were going to have to get into a debate with someone, a medical professional, who would suggest that a child at 22 weeks, a baby at 22 weeks gestation would not feel pain, how would you like your chances of arguing that debate based on the data?

Dr. Malloy. In my written testimony, I submitted the multiple references that talk about neurological development, brain development, multiple studies that--a great one that I think is a clear view is there was a study that looked at babies who had intrahepatic needling, so actually a blood draw into the liver for a purpose to get blood studies from the baby, compared to that same blood drawn from the umbilical cord of the baby, because you can get the blood that way, too, and the difference was night and day between the baby felt the needle in the liver and the baby did not feel the needle in the umbilical cord. So it is pretty black and white. I mean, that--there are so many studies published. I could not even--there are at least 20 in my written testimony.

Senator Tillis. Dr. Aultman, do you agree with that or do you have anything to add? Then I have a final question for Ms. Ohden.

Dr. Aultman. I would totally agree with that, and I just wanted to remind you that when she and I speak about age, you guys are talking about 20 weeks gestation, to us that is 22 weeks, and that is what most lay people consider it, 22 weeks. And that is when you start to see viability.

Senator Tillis. I think that is a very important point that we need to educate more on as we continue this discussion.

Ms. Ohden, I for one think that if a baby is born as a result of a failed abortion, that is a new patient, that in the United States that is a new American citizen, and that there is an obligation on the part of the health professionals to do everything that they can to protect that life. I actually delivered my second baby, my son, and just shortly after his delivery, he had a respiratory problem. He had to be whisked away, but I had gotten to hold him, literally I caught him. But then my wife did not. Now, I know this is a little bit different circumstance where some would argue that maybe the disposition of that child, that child's life, should be left in someone else's hands. I for one do not believe that that should be. I think at that point in time we have a new American citizen that we should protect.

So when you have heard the discussion about, you know, some who believe that your fate should have been in the hands of someone else in the room, how does that make you feel?

Ms. Ohden. I am sure you can all imagine what it is like for me, right? When we talk about who the patient is, you know, people here today have made it clear who the patient of the abortionist is. The patient is the mother. No one who is here in support of abortion today said that the child was the patient. I was the patient after I was

delivered that day. I was the one who was still left to die. I was the one who, thankfully, had nurses fight for medical care to be provided to me. My life should not have been hanging in the balance that day for two nurses who, thankfully, stepped in and fought for me.

And like you, Senator, I am actually the parent of a child with complex medical needs. I have two little girls. One is almost 8, and the other one is 19 months. And like Ms. Zink, I went into an ultrasound at 20 weeks, excited to see the life within me, and had the wind knocked out of me. What they thought she had at the time was a condition where her lymph was just simply going to stop accumulating around her lungs. It was supposed to just go away. Future scans actually show that our daughter was perfectly healthy, and then, lo and behold, when she was born, she faced many, many medical problems. She had two surgeries before the time she was 4 months old. She had a complication that left her there for an entire month. She had chest tubes draining the fluid off of her lungs. My daughter had a feeding tube for many, many months before I could continue to work with her so she could gain the skill she needed to eat. My daughter is now 19 months old. Has she suffered? Yes, she has. But I cannot imagine my child not being alive today. And we have every reason to believe she will go on to lead a pretty normal life, and her life could have very much been in

jeopardy. I think if the doctors would have known about the condition she would have faced, I would have been counseled to abort her. That never would have been an option in our world. But I just want to make that clear. I know what it is like, Ms. Zink, to experience those things. And I know we have a very different worldview, but our story, so many people have experienced that.

Senator Tillis. Thank you.

Thank you, Mr. Chair.

Senator Graham. Senator Blumenthal.

Senator Blumenthal. Thanks, Mr. Chairman. I want to focus for the moment on a threat to life closely related to the one that is the subject of testimony today, and that is the threats, intimidation, violence directed at clinics that provide reproductive services. For the record, I would like to submit a letter that is written by David Cohen, a professor at Drexel University School of Law, if there is no objection.

Senator Graham. Without objection.

[The letter follows:]

/ COMMITTEE INSERT

Senator Blumenthal. It contains some of the statistics that all of us know from reading the papers are very much a part of this world. The overall percentage of clinics impacted by threats and targeted intimidation has increased dramatically since 2010, from 26.6 percent of all the clinics to now more than half of them, 51.9 percent are targets of intimidation, threats, and actual violence. And we know that those threats often become real-life action in death and injury. In fact, there were ten attempted or successful arsons or bombings between 2010 and 2014 at abortion providers and clinics, 78 acts of vandalism, 503 acts of trespassing, 15 incidents of assault and battery, 13 death threats, 19 bomb threats, and then there were the actual bombings and fires and so forth.

So in the real world, these threats are a real and present danger, and the question is why they have been increasing. And I think we can all agree--I hope everyone on the panel agrees--that these kinds of threats and actual violence should be discouraged and deterred and prosecuted. Do you all agree?

For the record, everybody is nodding.

And so the question is what we can do to stop it or at least reduce this kind of violence, because the rule of law really requires that there be protection for people who seek these services as well as the providers who make it possible

for women to have these services.

I have long believed that we need to increase the penalties under the FACE statute, that is the 1994 Freedom of Access to Clinic Entrances statute. I have enforced it as a State Attorney General. And stiffer penalties might be a good deterrent, better fund the Department of Justice unit that is assigned to enforcement. The unit needs full resources for its lawyers and agents to be able to make and bring these cases, as well as increase the civil penalties that can be applied against individuals who violate this law.

There is also very possibly the need to better protect the identities of the professionals who work in these clinics and to fund support at the local level for activities that protect the clinics.

But at the end of the day, some of this violence is encouraged by the political rhetoric that is used, the political rhetoric that is becoming itself more coarse and vituperative. And I hope that we can take from this hearing perhaps a message that science and law should be the guiding references, not the political rhetoric of the campaign trail or even of the Senate floor. And I want to thank all of you for being here today. I hope that maybe there is some common ground, some bipartisan common ground, and that we can work together toward it.

Thank you.

Senator Graham. Thank you.

I do not see anyone else here. I will just wrap it up. Thank you all for providing testimony to the Committee on, I think, a very important topic. Number one, I am not encouraging--I want to condemn any act of violence. I mean, you have to follow the law, whether you like it or not. You can peaceably protest, but it does not give you the right to hurt anyone. So I am trying to make a law. I am trying to make a law that I think would be good for the country as a whole, would put us in good standing as a Nation. And it is a simple concept. At 20 weeks, you cannot have an abortion unless the mother's life is at risk, or as a result of rape or incest. That puts us in the norm of where most of the nations are, and that is all I am trying to do, because I do believe a baby can feel pain. I think there is a legitimate state interest to protect a child that cannot be operated without anesthesia from an abortion that has got to be a very painful procedure.

Just one last question. Dr. Malloy, when you perform life-saving procedures or medical procedures on a 20-week child, you provide anesthesia. Is that correct?

Dr. Malloy. Yes, we have been providing anesthesia.

Senator Graham. Okay. Are you reimbursed by insurance companies or the Federal Government on occasion?

Dr. Malloy. I actually do not think--I do not know.

Senator Graham. You do not know?

Dr. Malloy. The doctors do not have to deal with the finances.

Senator Graham. Yes, okay. The bottom line is I would doubt if anybody is going to deny the anesthesia bill. So the point is that I think it is pretty well accepted medical practice that babies at this point in time are operated on with anesthesia to get the best result, because they can feel pain.

Thank you all very much for the hearing, and the hearing stands adjourned. The record will be open for 1 week. Thank you.

[Whereupon, at 11:54 a.m., the Committee was adjourned.]

C O N T E N T S